Resection of a large ileal lipoma exhibiting ball-valve prolapse into the cecum with a “grasp-to-retract, ligate, unroof, and let-go” technique

Fig. 1 Endoscopic image of an ileal submucosal lesion with a normal overlying mucosa. The lesion has prolapsed through the ileocecal valve into the cecum.

Fig. 2 Endoscopic image showing retraction of the lipoma into the terminal ileum.

Fig. 3 Endoscopic image depicting the use of a grasping forceps to pull the lipoma toward the ascending colon, allowing placement of the endoloop.

Fig. 4 Endoscopic image revealing the extrusion of fat – the “naked fat” sign – after endoloop ligation.

Fig. 5 Endoscopic image showing unroofing after snare resection of the top of the tumor for tissue sampling.

Fig. 6 Narrow-band imaging and electronic zoom to 1.2× magnification reveal a scar with no residual lesion.

A 51-year-old woman was referred to our department for endoscopic resection of a symptomatic ileal lipoma, which had been detected during a previous colonoscopy performed to investigate a 6-month history of intermittent episodes of abdominal pain and diarrhea. Colonoscopy revealed a large, yellowish, pseudo-pedunculated ileal lesion with normal overlying mucosa that was prolapsed through the ileocecal valve into the cecum (● Fig. 1). Because of retraction of the lipoma into the terminal ileum with manipulation

(● Fig. 2, ● Video 1), a two-channel therapeutic colonoscope (CF-2T160I; Olympus America, Center Valley, Pennsylvania, USA) was used. The lipoma was pulled toward the ascending colon with a grasping forceps while an endoloop (MAJ-254; Olympus), previously placed over the forceps, was positioned and tightened around its base (● Fig. 3, ● Video 1). Endoloop ligation resulted in congestion of the mucosa and the extrusion of fat – the “naked fat” sign (● Fig. 4, ● Video 1). Subsequently, unroofing was accomplished

by snare resection of the top of the tumor (● Fig. 5, ● Video 1), histopathologic examination of which confirmed the clinical diagnosis. At follow-up colonoscopy 2 months later, the patient was asymptomatic, and a scar with no residual lesion was found (● Fig. 6).

Lipomas account for 21.4% of all benign small-bowel tumors and are located

Video 1

Management of a large ileal lipoma by applying the “grasp-to-retract, ligate, unroof, and let-go” technique with a double-channel therapeutic colonoscope.

mainly in the terminal ileum [1]. Larger lipomas may result in abdominal pain, constipation, and diarrhea and require resection to avoid complications [1–3]. Although surgical resection has been used traditionally, the endoscopic removal of lipomas is increasingly being reported [1,3]. Unlike endoscopic snare cautery of large subepithelial tumors, endoloop has a negligible risk of bowel perforation because it involves the slow mechanical transection of large pedunculated lipomas [2–4]. Its main pitfalls are the lack of a specimen for examination and the eventual need for additional ligation procedures to complete resection of the lipoma [2,4,5]. Nevertheless, the unroofing technique allows spontaneous enucleation of the lesion and tissue sampling [5]. This “grasp-to-retract, ligate, unroof, and let-go” technique constitutes a safe and successful approach to the management of prolapsing ileal lipomas.

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Ana Ponte¹, Rolando Pinho¹, Silvio Vale², Carlos Fernandes¹, Iolanda Ribeiro¹, Joana Silva¹, João Carvalho¹

¹ Department of Gastroenterology, Centro Hospitalar Vila Nova de Gaia, Espinho, Portugal

² Department of General Surgery, Centro Hospitalar Vila Nova de Gaia, Espinho, Portugal

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Corresponding author

Ana Ponte, MD

Department of Gastroenterology
 Centro Hospitalar de Vila Nova de Gaia
 Rua Conceição Fernandes
 Vila Nova de Gaia 4434-502
 Portugal
 Fax: 351-22-786-8369
ana.ilponte@gmail.com